

**UNITED STATES GOVERNMENT
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 27**

St. Anthony Hospitals,¹

Employer,

Case 27-RC-8052

and

Service Employees International Union,
Local 105,

Petitioner.

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, herein called the Act, a hearing was held before a hearing officer of the National Labor Relations Board, herein called the Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

¹ The Employer contends that its correct name in this proceeding should be St. Anthony Hospital System, but the Petitioner would not agree to amend its petition, asserting that St. Anthony Hospitals is the correct name. Testimony presented by the Employer's general counsel established that at different times in the past, as well as in the present, the Employer has been known by various trade names, including St. Anthonys, St. Anthony's Health System, St. Anthony Hospital System, Provenant Health Partners, St. Anthony Health Services, and St. Anthony Hospitals. Apparently, none of these trade names have been legally registered. In the absence of compelling evidence favoring one name over another, the name under which the petition was filed will be used herein.

2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. The labor organization involved claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of the Section 9(c)(1) and Section 2(6) and (7) of the Act.

The Employer is a Colorado not-for-profit corporation operating a health care institution engaged in the business of providing acute care and other health care services in and around Denver, Colorado, including several mountain counties west of the Denver metropolitan area. The Employer employs over 1,000 part-time and full-time registered nurses (RNs) at its facilities located at nine different sites. The record contains no breakdown of employees by facility.

Recently, St. Anthony Hospitals affiliated with the Adventist Hospital System under Centura Health, a joint venture management company. This affiliation was intended to provide a health care system with statewide presence and to provide efficiencies of scale as well as advantages in negotiations with managed care companies. St. Anthony Hospitals is owned by Catholic Health Initiatives. Centura does not have any ownership interest, but provides some management functions for the Employer and has some policies that apply to all Centura-affiliated facilities. The record evidence establishes, however, that St. Anthony Hospitals is the employer of the employees involved in this matter.

The largest facilities operated by the Employer are its two acute care hospitals² known as St. Anthony Hospital Central (SAC) and St. Anthony Hospital North (SAN). SAC is located at 4231 West 16th Avenue in Denver, and SAN is located at 2551 West 84th Avenue in Westminster, Colorado, approximately 12 miles from SAC. Facilities located within SAC, other than the acute care hospital itself, include the Intermountain Neurosurgery and Neuroscience (IMNN) Clinic and Family Medicine West Clinic. The Employer's Transitional Care Unit (TCU), Senior Health Center, and Intensive Outpatient Program are facilities of the Employer located in the Senior Life Center building, which is two to three blocks from SAC. Other facilities of the Employer include the Senior Health Clinic at Range Vista (across the street from SAN), the Family Medicine Center North (two miles from SAN), Broomfield Family Practice (nine miles from SAN), Gilpin County After Hours Clinic (44 miles from SAN), Southwest Plaza Joint Venture (JV) After Hours Clinic (12 miles from SAC), Aurora JV After Hours Clinic (19 miles from SAC), and Summit County Medical Center (75 miles from SAC).

The Petitioner seeks to represent all full-time and regular³ part-time RNs who work at the Employer's two acute care hospitals, but would exclude those RNs working at all other facilities. The Petitioner would also exclude from the unit any RN working in a classification which does not require a RN license or in a position which does not have a community of interest with staff nurses. The

² The Parties stipulated at hearing that the two hospitals are acute care facilities and agreed that other facilities are not acute care facilities. Based upon that stipulation, and the relevant record evidence, I find that the two hospitals are the only facilities of the Employer which fall within the Board's definition of "acute care hospital" as set forth in 29 CFR § 103.30(f)(2).

³ The Petitioner requested in its post-hearing brief to amend the petition to seek only "regular" part-time RNs and that request is granted.

unit sought by the Petitioner would be comprised of approximately 775 RNs, according to information supplied by the Employer. The record does not indicate how these RNs are apportioned between the two hospitals, but it does indicate that SAC is a larger facility than SAN.

The Employer agrees that RNs at SAC and SAN should be included in the same bargaining unit, but contends that RNs employed at its other facilities should also be included. The Employer also maintains that RNs who serve as team leaders should be excluded from the unit as statutory supervisors, but the Petitioner contends these RNs are not supervisors and should be eligible to vote. The unit of RNs which the Employer claims is appropriate would consist of over 1000 full-time and part-time registered nurses.

APPLICATION OF THE HEALTH CARE RULE

The National Labor Relations Board's Final Rule on Collective Bargaining Units in the Health Care Industry, 29 CFR § 103.30; 284 NLRB 1580, 1596 (1989) (Rule), established that, except in extraordinary circumstances, an acute care hospital unit limited to registered nurses is appropriate. The unit sought by the Petitioner here is limited to RNs at the Employer's two acute care hospitals. If the Petitioner sought a single unit of RNs at one of the two hospitals, either of those units would clearly fall under the Rule, and the Board's single-facility

presumption might also apply. See, e.g., *Visiting Nurses Assn. of Central Illinois*, 324 NLRB 55 (1997). Likewise, if the Petitioner sought separate RN units at both hospitals, there is no reason why the Rule would not apply, even though the appropriateness of separate units might be subject to adjudication.

Here, however, the Petitioner seeks a RN unit which covers both SAC and SAN in a combined unit. The appropriateness of limiting such a dual-facility unit only to RNs would seem to fall under the Rule and not be subject to adjudication. This would appear to be true even though the appropriateness of a dual-facility unit would be subject to adjudication. The Parties have agreed, however, that the dual-facility unit is appropriate, and, therefore, it is not necessary to adjudicate that issue.⁴ The fact that the Employer would also like to add to the unit RNs who do not work in the acute care hospitals does not override the Rule simply because the petitioned-for unit covers more than one facility.

To state the matter differently, the appropriateness of limiting the dual-facility unit only to RNs is covered by the Rule and is not subject to adjudication. The question of the appropriateness of a dual-facility unit of RNs, as opposed to separate single-facility units of RNs, may be subject to adjudication, but there is no dispute regarding that issue. The Parties are in agreement that a combined unit of RNs at both hospitals is appropriate, and I find that the record evidence

⁴ Even without the Parites' agreement, I find substantial evidence in the record to support a conclusion that SAC and SAN have a higher degree of integration than either has with other nonacute care facilities. I note also that the technical employees at SAC and SAN are organized in a single bargaining unit which currently has a collective-bargaining agreement with the Employer.

supports that agreement. Barring extraordinary circumstances, the Rule will not permit the inclusion of RN's employed in nonacute care facilities.

As the facts discussed in subsequent sections demonstrate, this case does not present the kind of "extraordinary circumstances" needed to overcome the application of the Rule.

To satisfy the requirement of "extraordinary circumstances," a party would have to bear the "heavy burden" to demonstrate that "its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding," [such] as, for instance, by showing the existence of such unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field, that it would be unjust or an abuse of discretion for the Board to apply the rules to the facility involved.

53 Fed. Reg. 33900, 33933 (1988); 284 NLRB at 1574 (1989) (footnotes omitted). The arguments advanced here are not substantially different from those considered in the rulemaking proceeding and, therefore, the Employer has not met its burden to establish the existence of extraordinary circumstances in this case.

Therefore, since the Rule applies in this matter, I find that a unit limited to RNs at both acute care hospitals is appropriate and not subject to litigation. Accordingly, the Employer's claim that RNs who work in its nonacute care facilities should be included in the petitioned-for unit is rejected.

SCOPE OF THE UNIT

Facilities Not Part of the Acute Care Hospitals

Since the appropriateness of the petitioned-for unit is settled by the Rule, facilities which are not part of the acute care hospitals can be excluded without adjudication. Many of the RNs which the Employer would add to the unit are employed at non-acute care facilities which no party contends are actually a part of the Employer's acute care hospitals.⁵ Those facilities include the following:

Summit Medical Center

Summit Medical Center, which employs 59 RNs, is located in Frisco, Colorado, a mountain community approximately 75 miles west of Denver. It is licensed as a community clinic and emergency center, maternity hospital, and ambulatory surgical center/convalescent center. The facility has a total of 11 patient beds, but is not permitted to keep patients for longer than 72 hours, and typically no more than two patients stay overnight at any one time.

Granby and Gilpin Clinics

The Granby Clinic, which employs 11 RNs, is located in Granby, Colorado, a mountain community approximately 83 miles northwest of Denver. It is also licensed as a community clinic and emergency center, but is not licensed to keep any patients for overnight stays. The Gilpin County After Hours Clinic, which

⁵ The Employer claims that some acute care services are provided at the Summit Medical Center, but agrees that it is not an acute care hospital.

employs only one RN, is located about 44 miles west of Denver.⁶ The primary focus of the Gilpin Clinic is occupational medicine.

Broomfield Family Practice and the After Hours Clinics

The Broomfield Family Practice is an outpatient physician practice recently acquired by the Employer. It is located nine miles from SAN and employs seven RNs. The After Hours clinics at Southwest Plaza and Aurora, respectively 12 miles and 19 miles from SAC, provide outpatient intermediary medical services between a doctor's office and an emergency room. There are four RNs at the Southwest Plaza clinic and five RNs at the Aurora clinic.

The parties do not contend that the facilities described above are part of the Employer's two acute care hospitals, and there is no record evidence to prove otherwise. Therefore, since the RNs at these facilities are not employed at a facility which is part of either acute care hospital covered by the petition, I find that they should not be included in the acute care hospital RN unit which is appropriate under the Rule.⁷

Facilities Considered Part of the Acute Care Hospitals

Other facilities are located in close proximity to either SAC or SAN, and the Employer apparently contends that they should be considered part of the acute care hospitals. Those facilities include the following:

Family Medicine Clinics

⁶ The Employer moved post-hearing to admit Employer's Exhibit 2-A, primarily to correct the distance of the Gilpin After Hours Clinic from SAN. The Petitioner has not objected to the admission of this document, and the Employer's motion is hereby granted.

⁷ Even if the Rule did not exist, I would find that the RNs who are employed in these facilities do not have a community of interest with the RNs who work in the acute care hospitals. There are significant

Two of the facilities at issue are part of the Employer's family medicine residency program—the Family Medicine West Clinic, physically located within SAC on the ground floor, and Family Medicine North Clinic, located in a professional building at 7280 North Irving Street, two miles from SAN. The 32 residents presently in the program rotate through different area hospitals, including SAC and SAN, and the two clinics provide an ambulatory setting for the residents to see patients. RNs who work in the two clinics assist the residents in treating patients and performing procedures. At the time of the hearing, each clinic was run by a clinic manager who reports to the administrator for the Family Medicine Residency Program, who in turn reports to the program director for the residency program, a physician. The program director appears to report to the chief financial officer (CFO) for the Employer. This chain-of-command is different from that of the hospital patient care units, which report to the CEO through the vice-president for patient care services. Nevertheless, program administrator Gary Ruhl, whose office is in a building adjacent to SAC, testified that the Family Medicine West Clinic is considered a department of SAC.

The parties apparently contend that there is one non-supervisory RN⁸ employed at each of the Family Medicine clinics. After a careful review of the record, however, it appears that there is only one RN employed, Virginia Martinez, who transferred to the North clinic when a third clinic she was working at recently closed. Since the record contains no evidence that there is a non-

differences between the two groups of RNs in work schedules, responsibilities, supervision, and, most importantly, very little contact or interaction.

supervisory RN employed at the West clinic, I find it unnecessary to decide whether that clinic is part of SAC.

Regarding the North clinic, which does have one RN employed, there is insufficient record evidence to conclude that it is a part of SAN. Although Gary Ruhl testified that the West clinic was "considered a department" of SAC, he made no such representation regarding whether the North clinic was considered a department of SAN, and the chain-of-command for the North clinic provides no obvious connection to SAN. In any case, the mere fact that a non-acute care outpatient facility may be considered organizationally a part of an acute care hospital does not, without more, establish that it should be considered a part of the hospital for purposes of collective bargaining. This is especially so when, as is the case here, the outpatient facility is located two miles from the acute care hospital and there is insufficient evidence of functional or operational integration of the two facilities. I find, therefore, that the Family Medicine North Clinic is not a part of SAN.

Senior Services

The Transitional Care Unit (TCU), Senior Health Center, and the Intensive Outpatient Program are separate health care facilities of the Employer located in the Senior Life Center building two to three blocks from SAC. The building, also houses an Alzheimer's unit, a long-term care unit, and a long stay hospital, none of which are owned or operated by the Employer. The Senior Life Center has its own cafeteria and parking lot, and the building is not owned by the Employer.

⁸ Jane Thompson and Katy Krajewski, the two clinic managers at the time of the hearing, are RNs, but the parties stipulated that they are statutory supervisors. Based upon the stipulation, and the evidence

The Employer contends that its facilities located in the Senior Life Center are considered part of the SAC campus and would evidently argue that they are also a part of the acute care hospital. The same argument is also made with respect to the Senior Health Clinic at Range Vista, located across the street from SAN.

None of the senior service facilities provide acute care such as that provided in the Employer's acute care hospitals. Moreover, the TCU is a rehabilitation facility which the Board specifically excluded from the definition of "acute care hospital." 29 CFR § 103.30(f)(2). The Board noted in its rule making deliberations, however, that "[m]any of today's hospitals have a number of other types of units, such as outpatient clinics, nursing care units, etc., and the Board did not intend to exclude such hospitals from coverage of the rule unless any one of the excluded ancillary services predominated." Therefore, if these facilities are found to be a part of one of the Employer's acute care hospitals, the RNs employed in the facilities should be included in the unit if they share an "empirical community of interest" with the acute care hospital RNs. See *Park Manor Care Center*, 305 NLRB 872, 875 n.16 (1991).

I find, however, that there is insufficient evidence to conclude that any of the senior services facilities are part of the Employer's acute care hospitals, despite the record testimony that they are considered "departments" of the hospitals. Although personnel and administrative services have been centralized for all of the Employer's facilities, day-to-day labor relations are controlled by the on-site manager for each of the senior services facilities. In addition, the RNs at

presented in its support, I find that the clinic managers are supervisors.

the facilities are supervised separately and operate under a different chain of command.

The 13 RNs who work at the TCU care for inpatients who need rehabilitation before they can be discharged or transferred to a nursing home. Many of the patients are transferred from either SAC or SAN, but some come from other hospitals. Regardless, all patients must be discharged from an acute care hospital and then readmitted to the TCU. The Intensive Outpatient Program is a psychiatric clinic providing group and individual therapy, primarily to seniors. The three PRNs⁹ employed there assess medical status and provide nursing care as part of the therapy services. The Senior Health Center located in the Senior Life Center employs three RNs. The Senior Health Clinic located across the street from SAN, employs one RN. Both clinics provide outpatient medical services primarily to seniors.

All of these facilities have limited employee interchange with the acute care hospitals. They do not use the hospitals' regular float pool RNs.¹⁰ There is also no evidence that excess staff float between the facilities and the hospitals. The PRNs in the Intensive Outpatient Program are also employed in the SAC psychiatric unit, but their PRN outpatient duty constitutes a separate job and is not a hospital assignment. There was testimony that hospital RNs have also worked in the TCU, but the record does not indicate when, how often, and under what circumstances.

⁹ "PRNs," as discussed below, are part-time RNs who work as needed.

¹⁰ The TCU may have received some float pool assistance in the distant past, but at that time the unit was located within the SAC building.

Despite the physical proximity of the facilities to the hospitals and some administrative centralization, I find that the lack of significant functional and operational integration, including separate day-to-day control of labor relations, and little interchange or contact with hospital RNs, warrants a conclusion that the senior life facilities are not a part of the acute care hospitals. As facilities separate from the hospitals, the RNs employed there are not covered by the Rule and should not be included in the appropriate unit.

COMPOSITION OF THE UNIT

Although the petition seeks a unit of all RNs employed in the Employer's acute care hospitals, the Petitioner contends that certain RNs employed in those hospitals, and otherwise covered by the Rule, should be excluded because they work in classifications which do not require an RN license, because their function is primarily administrative, or because their duties are unrelated to the work of staff nurses in the acute care hospitals. The Employer maintains these RNs should be included in the unit.

The Board, in its rulemaking proceeding, left the precise placement of particular classifications which may be disputed in a particular case to the case-by-case adjudicative approach. 54 Fed. Reg. 16336, 16344; 284 NLRB 1580, 1592 (1989) The Board did not, however, specify what that approach should be. The "empirical community of interest" standard set forth in *Park Manor Care Center*, 305 NLRB 872, 875 (1991), applies to unit determination issues in nonacute care health facilities. I find that it is consistent with the

Board's intent to apply the broader "empirical" test to the determination of acute care hospital unit composition issues such as those present here.¹¹

The classifications which the Petitioner would exclude from the acute care hospital RN unit are discussed below. Of general significance for many of these classifications, the Board noted in its rulemaking proceedings that "[m]any of today's hospitals have a number of other types of units, such as outpatient clinics, nursing care units, etc., and the Board did not intend to exclude such hospitals from coverage of the rule unless any one of the excluded ancillary services predominated." 54 Fed. Reg. 16336, 16344; 284 NLRB 1580, 1591 (1989).

Factors present in certain classifications discussed below would argue in favor of excluding those classifications from the RN unit. In most cases where the decision is a close one, I have tipped the balance in favor of inclusion to avoid the possibility of the unit proliferation which concerned Congress. The interests of the nurses included for nonproliferation concerns appear to be more

¹¹ Alternatively, it could be found without regard to a community of interest analysis, that since, as discussed below, the IMNN Clinic RNs, case manager RNs, psychiatric triage coordinator RN, education/project specialists, parish nurse coordinators, and Flight for Life Program RNs should be included in the appropriate unit by virtue of the Rule alone because they routinely perform, or demonstrate and teach, RN functions within an acute care hospital, or as an operationally integrated ancillary service from a base within such a hospital. Similarly, it could be found without regard to a community of interest analysis, that as discussed below, the clinical outcomes coordinators, regulatory compliance coordinator, and physician services representatives, can be excluded from the appropriate unit by virtue of the Rule alone because they do not routinely perform RN functions within an acute care hospital.

closely aligned with those of nursing department RNs than with those of other professionals within the hospital. Therefore, given the choice between placing such residual RNs in one of two units—one composed of RNs or one composed of the remaining professionals—I find that the better choice under the circumstances here is to place these RNs in the same unit.

IMNN Clinic RNs

The Employer operates the Intermountain Neurosurgery and Neuroscience (IMNN) Clinic in a facility which is part of the SAC hospital building. The clinic provides inpatient and outpatient care to neurosurgery patients. Patients of the clinic often have surgery performed at SAC by clinic physicians and remain patients of the hospital during recovery. The clinic employs two RNs and two nurse practitioners, each of whom works 10 hours a week on the same schedule as the physician they are assigned to assist. The clinic nurses make hospital rounds with the physicians during which they perform specialized procedures as needed and other assistance. They report to a physician practice manager who is in charge of the clinic. The manager reports to a SAC administrative team headed by the Employer's chief financial officer. All clinic employees, including the nurses and physicians are employees of SAC, and the clinic is considered a department of SAC. The nurses use the SAC cafeteria and parking facilities, and they are covered by the system-wide personnel and benefit policies, the same as other RNs. The clinic nurses generally work regular day-shift hours.

Applying the empirical community-of-interest test, I note first that the Board has included non-nursing department RNs in the same unit with acute care hospital nurses. See, e.g., *The Long Island College Hospital*, 256 NLRB 202, 207 (1981) (kidney center, methadone clinic, alcoholism treatment).

Consideration of factors deemed relevant by the Board shows that IMNN nurses have different work schedules and supervision from that of other hospital nurses. Their responsibilities are somewhat different in that they do not continually monitor patients and the knowledge they possess is more specialized than that of the hospital nurses. On the other hand, the IMNN nurses do have continuous interaction with patients in both inpatient and outpatient settings. They also have the same wage rates, education, training, and licensing as other RNs. Although they do not have continuous contact with hospital nurses, they do have some interaction on a regular basis, and all of the IMNN nurses transferred to their present positions from hospital units. Moreover, the interests of the IMNN nurses appear to be more closely aligned with those of nursing department RNs than with those of other professionals within the hospital. Based upon the above, and the record as a whole, I find that the IMNN RNs and nurse practitioners¹² should be included in the appropriate unit.

¹² The parties stipulated that nurse practitioners should be included in the appropriate unit. Petitioner, however, objects to the inclusion of the IMNN RNs and nurse practitioners. It is unclear from the record if there are any nurse practitioners outside the IMNN Clinic. Therefore, without regard to this possibly inconsistent stipulation, I find substantial record evidence and Board precedent to warrant their inclusion in the RN unit.

Case Managers

The Employer has 20 case managers employed at its two hospitals, all of whom are RNs except five social workers.¹³ Their responsibilities include assessing patients at admission to determine if they meet criteria for inpatient or observation status. Relying upon test results, physician notes, patient charts, and face-to-face patient assessment, case managers formulate a patient's plan of care leading to discharge. The case managers are assigned to particular hospital floors, are indirectly involved in patient care on a daily basis, and work closely with the RNs. Social workers employed as case managers work with a partner nurse to receive certain assistance, including obtaining medical assessments of patients which they are not licensed to perform.

I find that those case managers who are RNs perform some nursing functions in the various patient care units of the acute care hospitals, and the fact that a RN license is not required for the position by the Employer is not controlling. There are apparently certain aspects to the job which do require a nursing license, and, in addition, RN training and experience is an asset for functioning in the position. Social workers bring their own unique skills and knowledge to the position, but must rely upon RNs for performing important facets of the job. I find that case manager RNs share a sufficient community of interest with other RNs in the acute care hospitals to be included in the same unit. They have similar working conditions, receive the same benefits, and are

¹³ One of the social workers is apparently assigned to the Transitional Care Unit.

subject to the same employment policies. Moreover, their function is closely integrated with the direct patient care function of the other RNs with whom they have regular daily contact and interaction, and the interests of the case manager RNs appear to be more closely aligned with those of nursing department RNs than with those of other professionals within the hospital. Finally, no clear precedent has been found regarding placement of employees performing duties equivalent to those involved here. Based upon the above, and the record as a whole, I find that RNs employed in the case manager classification should be included in the appropriate bargaining unit.

Education/Project Specialist

There are five Education/Project Specialists employed at SAC, three of whom work regular dayshift hours in the education department, and two of whom work variable hours and shifts on the medical recovery unit. Their responsibility is to educate the staff by providing training and conducting seminars and new employee orientation. The three education department specialists are salaried, and the other two are paid hourly. One of the specialists who works on the medical recovery unit specializes in pediatric care and cross trains staff in the medical/surgical unit to provide competent care to pediatric patients. She accomplishes this by spending time on the units to observe and coach the staff. The educational role of clinical RNs I and II, included in the unit by agreement of the parties, is the same as that of the specialists except that the clinical RNs are assigned to a particular unit.

The job description for these specialists requires that they be licensed RNs and possess the nursing skills and experience to mentor staff nurses in the performance of their nursing duties. I find that they have a significant community of interest with the RNs. Moreover, Board precedent supports their inclusion. See, e.g., *Ohio Valley Hospital Assoc.*, 230 NLRB 604 (1977); *Newton-Wellesley Hospital*, 250 NLRB 409, 414 (1980). Accordingly, I find that the Education/Project Specialists should be included in the appropriate bargaining unit.

Pastoral Nurse Coordinators¹⁴

There are two pastoral nurse coordinators, one with an office located at each hospital. The coordinators provide non-invasive nursing care, often in community churches and schools, including immunizations, blood pressure checks, and health status assessments. The coordinators are often assisted in providing these services by SAC and SAN staff nurses who volunteer their time. Patients in need of further medical attention are referred to appropriate agencies and facilities, including St. Anthony hospitals and clinics. The position requires an RN license and bachelor's degree, has a flexible work schedule, and is salaried. The SAN coordinator reports to the director of mission ministry, as well as to the SAN site administrator.

Although the coordinators do not provide any inpatient nursing care, the type of service they provide on an outreach basis is ancillary to the primary

¹⁴ This position is sometimes known as Parish Nurse Coordinator.

acute care hospital functions. They have significant contact and interaction with hospital RNs through their efforts to organize Employer authorized voluntary nursing services for the community. I find that this type of outreach program is equivalent in relevant respects to the home care RNs often included in hospital RN units by the Board. See, e.g., *Frederick Memorial Hospital*, 254 NLRB 36, 39 (1981); *The Long Island College Hospital*, 256 NLRB 202, 207 (1981). Accordingly, I find that the pastoral nurse coordinators should be included in the appropriate unit.

Flight For Life Nurses

The Flight For Life program, operated by the Employer, provides emergency air transportation to and from hospitals in the region. Transportation is provided by helicopters based at the Summit Medical Center and at SAN, as well as by a fix-winged aircraft which flies from Centennial Airport located south of Denver. The program employs 18 RNs, including a chief flight nurse discussed in the supervisory status section below, as well as paramedics and pilots. Only the RNs are employees of the Employer. The RNs in the program regularly rotate between bases at SAN, SAC, Summit, and, in some cases, Children's Hospital—an acute care facility not affiliated with the Employer. Twelve of the RNs are not pediatric specialists and do not rotate to Children's Hospital. Two RNs rotate to all four bases, and four RNs work only at Children's Hospital even though they remain St. Anthony Hospitals employees. Those who rotate do so every 12-hour shift, so that during any work week at least 14 of the

RNs work a minimum of one shift, and in most cases two shifts, at the Employer's hospitals—SAN and SAC.

When transporting patients, the RNs perform emergency nursing care similar to that performed by emergency department RNs at the acute care hospitals. After the patient has been transported to the hospital emergency department, the Flight For Life nurses sometimes remain in the emergency department to assist with treatment of the patient. During periods when air transportation is needed infrequently, Flight For Life RNs often help out in the hospital emergency departments between flights.

The flight for life RNs provide nursing care similar to that provided by emergency department RNs whose inclusion in the unit is not contested. Although much of their work is performed while transporting patients, they are based in the hospitals a significant portion of their work schedule, assist in the hospital emergency departments at times, and have contact and interaction with hospital RNs on a regular basis. The Board has included emergency department RNs in hospital RN units. See, e.g., *Milwaukee Children's Hospital Assoc.*, 255 NLRB 1009, 1010 (1981). I conclude that this precedent should apply equally to Flight For Life RNs because of the similarity of their duties. Accordingly, I find that the Flight For Life RNs who regularly rotate to SAC or SAN should be included in the appropriate unit. Those RNs based at Children's Hospital who do not rotate to either SAC or SAN should not be included in the appropriate unit because they have little opportunity for contact and interaction with the hospital RNs.

Psychiatric Triage Specialist¹⁵

The Employer uses psychiatric triage specialists in its two acute care hospitals to perform assessments of patients' mental status and physical needs and to make recommendations regarding hospitalization. The specialists must have either an RN license or a bachelor's degree in psychology. Only one of the specialists is an RN. The RN specialist evaluates patients in every unit of the hospital, but frequently in the emergency department. The specialist consults with the nursing staff regarding the diagnosis and treatment of patients, and attends meetings and case conferences where the patient's progress is evaluated. The psychiatric triage specialist reports to the psychiatric triage coordinator and appears to be within the patient care chain-of-command.

Although an RN license is not required to perform the work of the triage specialist, licensed RNs are qualified to perform the job if they have had the appropriate experience. The RN psychiatric triage specialist would appear to be performing an RN function similar to that of RNs who work in the hospital psychiatric unit and whose inclusion in the appropriate unit has not been challenged. Based upon the above, and the record as a whole, I find that the RN psychiatric triage specialist should be included in the appropriate bargaining unit.

¹⁵ The Hearing Officer stated on the record that the Parties had agreed to include the RN psychiatric triage specialist in the unit and no disagreement with that statement was expressed. In its post-hearing brief, however, the Petitioner apparently takes the position that the RN specialist should be excluded because other specialists positions are filled by non-RNs. Because of this confusion, I have not relied upon the asserted stipulation.

Clinical Outcomes Coordinators

There are four clinical outcomes coordinators assigned to the Employer's acute care hospitals. One is a nuclear medicine technologist, one is a laboratory technician, and the remaining two are RNs. Clinical outcomes coordinators are responsible primarily for improving the quality and efficiency of patient care by coordinating and assisting with studies to identify best practices to be used throughout the organization and by evaluating clinical processes and outcomes, utilization of resources, financial impact, risk management, and customer satisfaction. One of the RNs coordinates a patient care quality improvement committee chaired by the director of nursing. The other RN, at the time of the hearing, had been working for 18 months with a group of nurses to redesign and streamline nursing documentation. Other issues the coordinator RNs have worked on include how nurses dispense and document narcotics, how nurses handle the situation when a patient dies, and how medication errors can be prevented.

The clinical outcomes coordinator position does not require a RN license and the RNs serving as coordinators do not engage in direct patient care or perform any other typical RN functions. The position is salaried and appears to be administrative in nature. The Board has held that positions which are predominantly administrative do not share a community of interest with RNs. *Addison-Gilbert Hospital*, 253 NLRB 1010, 1011-12 (1981). Accordingly, the RN clinical outcomes coordinators should not be included in the appropriate bargaining unit.

Regulatory Compliance Coordinator

The position of regulatory compliance coordinator is the same as that of the clinical outcomes coordinator except that it is concerned with outcomes related to regulatory compliance. This coordinator is responsible for facilitating hospital compliance with standards established by various regulatory agencies. The position is salaried, does not involve direct patient contact, and does not require a RN license. Like the clinical outcomes coordinator position, I find that the regulatory compliance coordinator position is predominantly administrative in nature and does not have a community of interest with RNs. Accordingly, the regulatory compliance coordinator should not be included in the appropriate bargaining unit.

Physician Services Representatives

The Employer employs a physician services representative at both of its hospitals, and they both are apparently licensed RNs. Their job is to serve as a liaison between the hospital department leaders and the physicians who use the hospital, in order to promote physician recruitment and retention. In fulfilling this marketing or public relations function, the physician services representatives help resolve physician complaints and implement programs to enhance working relationships with the physicians. The representatives regularly visit physician offices to work with their staff on hospital utilization issues, and spend about two hours a day talking with physicians in the hospital doctor's lounge regarding their concerns. They also make rounds with a physician about once a week and may occasionally assist with procedures on these rounds.

The physician services representatives are salaried employees. The representative at SAN testified that she reports directly to the site administrator at that hospital, although job descriptions for the two representatives indicate that they report to the director of physician services, a department directly under the CEO who is over both hospitals. Despite this confusion in the record, the representatives are certainly outside of the patient care chain-of-command.

The record contains two different job descriptions for the physician services representatives, one of which indicates that a RN license is required and the other of which does not have that requirement. The job descriptions do not contain any job duties which would seem to require an RN license. Although these representatives may engage in minimal direct patient care when making occasional rounds with physicians, those do not appear to be required duties. The SAN representative testified that she teaches CPR, basic life support, and other in-service-training topics to hospital staff nurses as well as those in physicians' offices. These duties, however, are not specifically covered by the job description for her position, and, in any case, there is no indication in the record that they require an RN license.

Based upon the record evidence, I conclude that the physician services representative position is one for which RN knowledge and experience may be helpful, but the representatives are not actually required to perform any duties for which a RN license is necessary, and the RN duties which they do perform are limited and incidental to their primary function. As with the coordinator positions discussed above, this position is closely aligned with administrative or managerial

concerns and does not have a community of interest with RNs. Accordingly, the physician services representatives should not be included in the appropriate bargaining unit.

SUPERVISORY AUTHORITY

At the time of the hearing, the Employer had approximately 20 RNs either classified as, or functioning as, team leaders. The Employer contends all these RNs are statutory supervisors and should be excluded from the appropriate unit. The Petitioner maintains that they are not supervisors under the Act and should be included. The Parties also disagree regarding the supervisory status of the chief flight nurse. The Employer would include that position, but the Petitioner maintains it should be excluded because of supervisory status.

Team leaders are hourly paid RNs who were previously known as "charge nurses," at least in some hospital units. They are paid slightly more than staff RNs, but clinical RNs have a higher wage range than team leaders. Eight of the team leaders at issue are employed in the SAC emergency department which has 90 full-time and part-time employees. The medical recovery unit of SAC has five team leaders and approximately 69 full-time and part-time employees. The SAN emergency department has four team leaders and approximately 75 full-time and part-time employees. Two team leaders are employed at the SAC surgery department, with a third position posted at the time of the hearing, and the department has approximately 35 full-time and part-time RNs. There is one team leader working in the SAN surgery department, with a second position

posted at the time of the hearing, and the department has approximately 46 full-time and part-time employees.

Section 2(3) of the Act excludes "any individual employed as a supervisor" from the Act's definition of "employee," thereby excluding supervisors from the Act's protections. To support a finding of supervisory status, an individual must possess one or more of the indicia set forth in Section 2(11) of the Act. The statutory criteria are read in the disjunctive and possession of any one of the indicia listed is sufficient to make an individual a supervisor. *Providence Hospital*, 320 NLRB 717 (1996). In *Providence Hospital and Ten Broeck Commons*, 320 NLRB 806 (1996), the Board decided that it would henceforth analyze the supervisory status of nurses under the Board's traditional test—whether the nurses in question possess any Section 2(11) authority and whether the performance of that authority requires the exercise of independent judgment. Under that test, the burden of proving supervisory status rests with the party asserting that status. *Youville Health Care Center, Inc.*, 326 NLRB 495, 496 (1998); *Bennett Industries*, 313 NLRB 1363 (1994). Moreover, because supervisors are excluded from the protections of the Act, the Board is cautious in finding supervisory status.

Applying this test here, I find that the burden of demonstrating that the RN team leaders and the chief flight nurse are statutory supervisors has not been met. The Employer here claims that its team leaders possess a number of indicia of supervisory status, as discussed below. The Petitioner claims that the

chief flight nurse is a supervisor, but the record does not indicate what specific supervisory authority the Petitioner believes this nurse exercises.

Supervisory Status of Team Leaders

Assignment and Direction

There is record evidence that team leaders make daily patient assignments to staff RNs by matching skills and competency of staff with patient needs. In the emergency departments, the team leaders assign staff to teams based upon qualifications, experience, and training, and also consider such factors as previous room assignments of the RN and sometimes the preference of the RN. A team is responsible for covering certain rooms and, since different rooms are set up for different procedures, patients are assigned to rooms based on the nature of the emergency. The team members then decide which RN will handle a particular patient. RNs assigned to triage must have a minimum of one year experience, and those assigned to pediatric cases must be certified for that age group.

In the surgery departments, RNs are assigned to particular operating rooms based upon the skill level and expertise of the RN as well as the comfort of particular nurses with the procedure to be performed, the instruments to be used, or the preferences of the surgeon performing the procedure. On the medical recovery unit, patients are assigned by the team leader on the previous shift, and the assignment may sometimes be changed if a patient is too difficult for a particular RN.

There is also record evidence that team leaders on some units prepare work schedules for six-week periods, and in other units the schedules are prepared by a staff member other than a team leader. Employees are permitted to self-schedule, and a computer program used for preparing schedules contains the hours that employees are available to work, and the person using the program simply makes minor adjustments.

A staffing matrix is available for guidance in preparing schedules. The matrix indicates the number of staff required based upon patient census levels. In the surgery departments, the number of staff to be scheduled is based upon the number of operating rooms that will be in use at a particular time, allowing two employees per room with additional staff for breaks. The nurse manager in some units, an agreed supervisory position,¹⁶ reviews the schedule prepared by the team leader. In some cases, team leaders approve shift trades if the experience level of the RNs is the same and no overtime will be involved. Vacation requests usually are submitted to the nurse managers.

If a unit is overstaffed on a particular day based upon the patient census, the extra staff is reported by the team leader to the staffing office at the beginning of the shift, and the staffing clerk instructs the team leader regarding where the extra employee should be sent if there is a need for staff in other units. If an employee must be sent home due to overstaffing, there is an established routine for selecting the employee to leave and volunteers are almost always

¹⁶ The Parties stipulated that nurse managers are statutory supervisors. Based upon the stipulation, and record evidence, I find that they should be excluded from the appropriate unit as supervisors.

forthcoming. If a volunteer cannot be found, the employee required to leave would be determined according to an established policy.

If a unit is short staffed on a particular day, the team leader is authorized to seek volunteers to work. They telephone employees from a list until they find someone willing to work. That employee may be entitled to overtime or a bonus based upon an established policy. Bonuses are paid automatically when employees are asked to work less than 24 hours before the beginning of the shift. At least in some units, nurse managers approve the overtime and bonus after the employee has worked the extra shift.

As with every supervisory indicium, assignment must be done with independent judgment before it is considered to be supervisory under Section 2(11) of the Act. *Providence Hospital*, 320 NLRB 717, 727 (1996). Routine or clerical assignments, such as those here, do not involve independent judgment. Assigning patients to RNs based upon assessment of employees' skills when the differences in skills are well known has been found to be routine. *Clark Machine Corp.*, 308 NLRB 555, 555-56 (1992).

In the SAC medical recovery unit, patient assignments are made by the team leader on the previous shift, and the record contains no evidence that this person has specific knowledge regarding the different skills of the employees on the next shift, suggesting the routine nature of the initial assignments. If the assignments prove to be inappropriate because a patient is too difficult for a particular employee, adjustments are made. The record provides no evidence

regarding how often these adjustments are necessary or whether they are made on the basis of anything other than the "well known" skill levels of employees.

Patients in the emergency departments are assigned by the team leaders to particular rooms, rather than to particular employees. To the extent that assessment of employee skills may dictate room assignments, the record does not indicate how often that occurs or whether the assessment is based upon anything other than "well known" skill levels or specialized knowledge or training. Likewise, patient or procedure assignments in the surgery units is based upon an assessment of employee skills, but it cannot be concluded based upon the record that employee skills are not well known. Accordingly, I find that patient assignments are routine tasks which do not involve the independent judgment required of statutory supervisors.

To the extent that team leaders are involved in preparing six-week work schedules, that function also appears to involve routine judgment. Elizabeth Steele, a team leader in the SAC emergency department, testified that team leaders do not prepare the schedule in that department. Martha Gowans, team leader on the SAC medical recovery unit testified that team leaders have no function in preparing the schedule because they have self-scheduling, with the first to sign up receiving the preferred shifts. Also, Kathleen Casidine, a team leader in the emergency department at SAN, testified that they have self-scheduling and that they turn their schedule in to the nurse manager. To the extent that team leaders may be involved in scheduling in some units, it appears from the record that their role is limited to filling in gaps in the schedule using

PRNs and per diem employees. The limited role of team leaders in the scheduling process clearly does not involve independent judgment.

The Employer claims that team leaders can authorize vacation and other leave without approval of higher management. The record evidence offered in support of this assertion shows, however, that only one team leader, Marie Mizek, is claimed to have such authority. The record provides insufficient information to determine to what extent approval of such leave involves independent judgment.¹⁷ Since, as discussed below, Mizek will be permitted to vote subject to challenge for other reasons, her authority with respect to granting leave requests can be clarified and resolved through the challenge procedure, if necessary.

Regarding the Employer's claim that team leaders have authority to require overtime or to send employees home if they are not needed, the record evidence shows that they only have the authority to solicit volunteers to leave work early or to work past the end of their shift. Although Employer witnesses suggested that team leaders have authority to require employees to leave early or to work overtime, they agreed that volunteers are usually obtained and preferred. If such authority exists, there is no evidence that it has ever been exercised by a team leader.

Several team leaders testified that they only have authority to seek

¹⁷ I note that in one hospital unit a non-supervisory staff member prepares the six-week work schedule and routinely approves vacation requests after verifying the employee has the leave time available and, if more than two employees have requested the same time off, the two most senior employees receive the time off. If Mizek follows similar routine procedures in approving vacation time, such authority would fall short of establishing supervisory status.

volunteers for overtime work or to leave work early. In the event there are no volunteers to leave early, there is an established policy to determine who should leave, usually based upon rotation. One team leader stated that if she had trouble finding someone to work overtime, she would check with the hospital manager or page the nurse manager. When employees are called in to work an extra shift, the team leader selects someone from a scheduling list based upon factors such as proximity to the facility and whether the staff member will incur overtime. The team leader solicits someone who will incur overtime or be eligible for a bonus only if there is no other choice.

Under these circumstances, I find that the record does not establish that team leaders have authority to require someone to work overtime and do not exercise independent judgment in calling in employees to work. See *Beverly Manor Convalescent Centers*, 275 NLRB 943, 946 (1985) (calling in an employee to assure adequate staffing is not indicative of supervisory status). The fact that calling in an employee may involve overtime or a bonus for the employee is incidental, especially, as here, where the record shows that the team leaders have no authority to order an employee in to work, or to discipline an employee who refuses to come in. *Id.*

To the extent that team leaders can require someone to leave early, the choice does not involve independent judgment since the decision is based upon an established policy. See, e.g., *Evangeline of Natchitoches, Inc.*, 323 NLRB 223, 224 (1997) (LPNs not supervisors, even though they found replacement

employees, because the LPNs followed standard procedure within established guidelines).

The Parties stipulated at hearing that team leaders Nancy Lott and Marlene O'Kane are statutory supervisors. Based upon that agreement and supporting record evidence, I find that these two employees are supervisors and should be excluded from the appropriate unit. The Employer argues, apparently, that the agreement to exclude O'Kane and Lott was based upon assignment duties equivalent to those of other team leaders, and therefore, other team leaders should also be found to be supervisors. I note, however, that the record contains an agreement by the Parties that O'Kane and Lott use independent judgment in their assignment duties. There is no such agreement regarding assignment duties of other team leaders, and the evidence does not support such a conclusion. There is also insufficient record evidence to support any claim that O'Kane and Lott perform the same assignment duties as the other team leaders.

There is little testimony specifically referring to how team leaders may direct the work of RNs or other employees. Team leaders are generally responsible for coordinating patient care within their units. They monitor other employees' skills and performance and intervene in case of problems. This function, however, is also performed by clinical RNs who are not alleged to be supervisors. Team leaders are expected to report performance or safety problems, but all RNs make such reports as part of their responsibility as licensed nurses. I find that the team leaders' direction of employees does not

require the use of independent judgment, but is merely routine or clerical in nature. Although team leaders do exercise judgment in assessing patients' conditions, that appears to be an exercise of their professional judgment as RNs and, as such, is a responsibility shared by all staff RNs. Based upon the record evidence, I cannot conclude that team leaders exercise independent judgment in their direction of employees.

The Employer further asserts that supervisory status is established by the team leaders' authority to authorize breaks. Much of the evidence relied upon by the Employer is in the form of conclusionary responses by witnesses to leading questions. Such statements, without supporting evidence, do not establish supervisory authority. *Sears Roebuck & Co.*, 304 NLRB 193, 193 (1991).¹⁸ The remaining evidence also fails to support a claim of supervisory status.

In at least one hospital unit with team leaders, breaks are scheduled or worked out by the employees themselves, with team leaders resolving any problems that arise. There is no evidence regarding how often problems arise or how the team leaders resolve them. In another unit with team leaders, the role of the team leader is to see that employees can take their breaks by caring for that person's patients, or arranging for someone else to do so. This limited role in scheduling or authorizing breaks does not involve the independent judgment

¹⁸ I note also that other conclusionary responses to leading questions often occurred with respect to various topics, particularly with regard to whether team leaders exercise independent judgment. Where supporting evidence is not available, I have not relied upon such responses alone in determining the issues herein.

required of a statutory supervisor. See *Providence Hospital*, 320 NLRB 717, 731 (1996).

Hiring

The Employer contends that the supervisory status of team leaders is also established by their role in the hiring process. The record shows that some team leaders, but not all, participate in hiring interviews by asking and answering questions and providing an assessment of the applicant to the nurse manager. The nurse manager conducts the interviews, and others often participate, including clinical RNs and staff nurses. All participants asks questions during the interviews and make recommendations regarding qualifications to the nurse manager.

Mere participation in the hiring process, absent the authority to effectively recommend hire, is insufficient to establish supervisory authority. *North General Hospital*, 314 NLRB 14, 16 (1994). The recommendations of the interviewers here are reportedly given considerable weight by the nurse manager, but there is no evidence that the recommendation of the team leader carries more weight than the others or that anyone was hired as a direct consequence of a recommendation by a team leader. The Board has relied upon such factors in finding no authority to effectively recommend hiring. *The Door*, 297 NLRB 601, 602 (1990).

Further, it is undisputed that the hiring decisions are not based solely on the team leaders' recommendations without independent investigation by the nurse managers. Job applicants are always personally interviewed by the nurse

managers before making the ultimate hiring decision. Therefore, it cannot be said that the team leaders effectively recommend hiring. *Waverly-Cedar Falls Heath Care*, 297 NLRB 390, 392 (1989).

The Employer notes that, in the SAN emergency department, team leaders assign numerical rankings to applicants interviewed and the hiring decision is based upon those rankings. Other staff members present for the interview, such as clinical RNs, also provide numerical rankings. The nurse manager can ignore the rankings, but has always hired the person ranked the highest by the staff present for the interview. The team leaders and clinical RNs do not actually make a recommendation to hire, but, in so far as can be determined from the record, are merely providing a numerical assessment of the applicants' technical qualifications for the job. In this regard, I note that interviewers provide their numerical ratings in response to a list of questions provided for that purpose. Significantly, there is also no evidence that the rankings provided by team leader interviewers carry any more weight than those provided by other interviewers. Under these circumstances, it cannot be concluded that anyone has been hired in the SAN emergency department as a direct consequence of team leader recommendations. See *The Door*, 297 NLRB 601, 602 (1990).

The Employer asserts that at the SAC surgery department the hiring process has been turned over to the team leaders and the nurse manager only occasionally sits in on the interviews. A careful reading of the record, however, reveals that Marie Mizek, a team leader who testified regarding this subject, was

referring to a situation in the past before the present nurse manager, Paula Golden, took over the department—approximately five years ago. At that time Mizek was a charge nurse and the team leader position had not yet been created, at least in that department. Since Golden became nurse manager, the record reveals that there have been no hiring interviews without the nurse manager involved, except for "travelers," or agency employees.

"Agency employees" are temporary employees hired for a day or two, and are often "booked" with the agency several months in advance. "Travelers" are employees hired through a different agency on a contract basis, usually for 13-week periods. Golden testified that Mizek does all the hiring for "travelers or contract" employees which they occasionally use. Since the record does not contain specific details regarding how often these employees are hired and the exact nature of Mizek's hiring role, it cannot be determined if independent judgment is involved. Accordingly, Marie Mizek will be permitted to vote, subject to challenge.¹⁹

Disciplining and Suspending

The Employer also contends that team leaders have supervisory authority in regard to discipline and suspension of employees. I find, however, that the exercise of their authority in this area requires no more than routine judgment. The record establishes that some team leaders monitor attendance and whether RNs carry their pagers. According to disciplinary guidelines, RNs receive a verbal warning for attendance problems and for not carrying a pager and after

¹⁹ Contrary to the Employer's suggestion, the record does not suggest that any other team leaders may be responsible for hiring travelers or agency employees without nurse manager involvement.

three verbal warnings, the next violation results in a written warning. There is no evidence that the team leader gives the written warning, but some team leaders apparently do give and document the verbal warnings.

The record evidence further establishes that team leaders seldom give any discipline without first checking with the nurse manager. Team leaders in the medical recovery unit seek advice from the nurse manager before giving verbal warnings for attendance problems. There is no evidence that they have ever suspended anyone, but they would be expected to consult with the nurse manager before doing so. Martha Gowans, a team leader in the medical recovery unit, testified that she has been told that she has the authority to issue written warnings for inappropriate nursing care or attendance problems, but she has never done so. She has also never suspended an employee, but would seek advice before taking any such action unless it involved a serious problem like intoxication.

Team leaders in the SAC surgery department bring attendance and other problems to the nurse manager who discusses the matter with the employee. Team leaders in that department have counseled employees, but a counseling is not considered discipline. Marie Mizek, a team leader in the SAC surgery department, testified that she has reprimanded employees on occasion, but has never issued written warnings or suspended anyone. She has provided feedback or collected data, mainly on attendance problems, at the request of the nurse manager. Before issuing any discipline, the nurse manager always talks to the employee to obtain their side of the story. Mizek once discovered that a

contract employee was charging for overtime not worked and reported the matter to the nurse manager. She and the nurse manager met with the employee and he was told at the meeting that his contract was terminated. Mizek also recommended that a RN receive a written warning for poor performance, but the nurse manager, after an independent investigation, gave a verbal warning instead.

Team leaders in the emergency department at SAN give written warnings only with the assistance of the nurse manager and after the nurse manager has talked with the employee regarding the problem. More serious discipline is handled by the nurse manager. Team leaders' recommendations regarding discipline are taken seriously, but clinical RNs also make recommendations regarding discipline. Kathleen Casidine, a team leader in the emergency department at SAN, testified that she has no authority to issue written warnings, but merely provides the information to the nurse manager. She also claims to have no authority regarding suspending or firing employees. Casidine issues occurrence reports, but the nurse manager decides the discipline without a recommendation from Casidine.

Elizabeth Steele, a team leader in the SAC emergency department, testified that she has never issued a written warning and has no authority to do so. She also stated she has no authority regarding suspending or firing an employee.

Team leaders in the SAN surgery department are expected to send home an employee for serious case misconduct, but only if the nurse manager is not

available. There is no evidence that this has ever occurred. They also document misconduct in personnel files, and such documentation is considered in evaluating the employee. The nurse manager, however, discusses the misconduct with the employee before relying upon it in the evaluation.

The Employer has not met its burden of showing that the team leaders can effectively recommend discipline. Discipline given automatically pursuant to established guidelines does not involve the exercise of independent judgment. See, e.g., *Evangeline of Natchitoches, Inc.*, 323 NLRB 223, 224 (1997). Moreover, it is well established that merely issuing verbal reprimands is too minor a disciplinary function to constitute statutory authority. See *Beverly Manor Convalescent Centers*, 275 NLRB 943, 945 (1985).

Of the four team leaders who testified, three stated that they did not have authority to issue written warnings. One reported that she never issued a written warning but had been told she had authority to do so for inappropriate nursing care, repeated tardiness, or repeatedly leaving early. The record contains evidence that, after three verbal warnings for attendance problems, the next violation will result automatically in a written warning. As noted above, discipline issued pursuant to established guidelines does not, without more, establish supervisory authority.

Documenting inappropriate nursing care is required of all RNs as part of their nursing role as patient advocates. The record does not specify whether the team leaders authority in regard to inappropriate nursing care extends beyond a nurse's normal advocacy role. In any case, there is no record evidence that team

leaders have ever given written warnings without consultation with, and assistance from, the nurse managers. Thus, the record evidence does not support a conclusion that team leaders exercise independent judgment regarding written warnings.

Moreover, even if team leaders do have and exercise the authority to issue written warnings, the record does not indicate whether such warnings contain recommendations for further discipline or whether they contain a warning that further infractions will lead to suspension and discharge. Without such inclusions, the team leaders perform only a reportorial function. *Passavant Health Center*, 284 NLRB 887, 889 (1987).

Even assuming that the written warnings do contain recommendations for further discipline and also a warning regarding consequences for further infractions, the record fails to establish that discipline documented in employee files independently affects an employee's job status or tenure. On the contrary, the record seems clear that higher management independently investigates employee misconduct or job performance before suspension or termination occurs. The record also indicates that nurse managers normally independently investigate before written warnings are issued involving all but the most routine infractions. Therefore, even if team leaders do occasionally issue written warnings to employees, under these circumstances it cannot be concluded that they effectively recommend discipline affecting job status or tenure.

As noted above, the team leaders who testified have never suspended anyone and deny having authority to do so without consulting with higher

management. The Employer claims that team leaders have authority to send employees home for misconduct such as intoxication and patient abuse. The exercise of such authority, however, would not establish statutory supervisory authority. The Board has typically found that such authority does not require independent judgment where its exercise is limited to situations involving flagrant or egregious misconduct that endangers patient health or safety. See *Vencor Hospital-Los Angeles*, 328 NLRB No. 167, slip op. at 4 (1999).

Adjusting Grievances

The Employer contends that team leaders have supervisory authority because they resolve conflicts that arise between employees in their units. The record establishes that they do not perform a supervisory grievance-adjustment function and do not participate in any formal dispute resolution procedure. Although the record provides few details on the subject, the team leaders seemingly have authority only to resolve minor problems and essentially act as mediators to remedy problems through mutual consent. The record indicates that employees often bring their complaints directly to the nurse managers and that problems which are handled by team leaders are reported to the nurse manager. Under these circumstances, I conclude that the Employer has failed to establish that team leaders adjust grievances within the meaning of the Act. See, e.g., *Ohio Masonic Home*, 295 NLRB 390, 392-93, 394 (1989).

Promoting and Rewarding

The Employer asserts that team leaders effectively recommend promotions and rewards by their evaluations of employees. Section 2(11) does

not list "evaluate" as one of the 12 identified supervisory functions. Accordingly, the role of evaluating employees, without more, cannot confer supervisory status. The Board's policy is that a worker's role in evaluating coworkers is not supervisory unless those evaluations "lead directly to personnel actions affecting those employees, such as merit raises." *Ten Broeck Commons*, 320 NLRB 806, 813 (1996). In other words, "for evaluations to constitute evidence of supervisory status they must *effectively* recommend personnel action." *Northcrest Nursing Home*, 313 NLRB 491, 498 (1993). "[A]uthority effectively to recommend generally means that the recommended action is taken without independent investigation by superiors, not simply that the recommendation is ultimately followed." *Children's Farm Home*, 324 NLRB 61, 61 (1997).

In this case, although there is evidence that team leaders informally report to management regarding the job performance of employees, particularly new hires, there is no contention that such reports include recommendations regarding promotions or rewards, including raises. Significantly, clinical educators also provide such evaluations of new employees. Although these reports may ultimately be weighed when higher managers consider personnel actions, there is no evidence that they lead directly to such actions without independent investigation.

The record establishes that team leaders participate in the annual appraisal of unit employees by submitting recommendations to the nurse manager. The nurse manager, however, prepares the evaluation and presents it to the employee. Team leaders are not necessarily even present when the

evaluation is presented. Nor do nurse managers rely exclusively on the recommendations from team leaders. They have opportunities to personally observe the work performance of unit employees, clinical RNs also evaluate new employees, and staff nurses participate in a peer review process of coworkers, at least in some cases. The record simply fails to show that evaluation recommendations from team leaders lead directly to personnel actions without independent investigation.

There is no dispute that team leader recommendations have no impact on salary increases of employees. The Employer has not given any merit raises since 1996, and the record contains no indication if or when such raises will ever be reinstituted. All employees who are eligible receive an annual raise in a uniform amount determined by the Employer's human resources department. The Employer maintains that a poor evaluation from a team leader could cause an employee to not receive this raise, but there is no evidence that any employee has ever been denied the raise based upon team leader recommendations.

There is evidence that an employee might be denied the annual raise for not meeting "competencies." Competencies are apparently examinations given by clinical RNs and also include requirements that RNs demonstrate skills in operating certain equipment. There is no evidence that team leaders are involved in these examinations, which are apparently a part of an employee's annual evaluation. In any case, there is no record evidence that employees have ever been denied annual raises for this reason.

The same conclusion has been reached with regard to the Employer's suggestion that team leaders effectively recommend promotions by their recommendations during the employee evaluation process. It is clear from the record that an employee's written evaluations are only one factor considered in promotions. Generally, candidates for promotions are interviewed jointly by the nurse manager and a group of peers, including clinical nurses, staff nurses, as well as team leaders. Recommendations made by the interviewers are considered by the nurse manager, who makes the ultimate decision. There is no indication in the record that team leaders' recommendations regarding promotions are given any more weight than the recommendations of others. I find, therefore, that there is insufficient evidence to conclude that team leaders effectively recommend promotions.

The Employer further claims that team leaders can effectively recommend employees for bonus payments because team leaders select employees to work extra shifts under circumstances which activate the Employer's bonus policy. As discussed above, the bonus policy is activated automatically when an employee agrees to work an extra shift with less than 24-hours notice. Soliciting employees to work in order to ensure adequate staffing requires only routine judgment, especially since staffing levels are predetermined by established standards. The fact that a bonus must be paid to an employee who agrees to work on short notice is incidental, especially where the team leader has no authority to order an employee to work and the incentives policy is not subject to the team leader's discretion. The only discretion involved is whether to seek last

minute staffing assistance, and the Board has determined that the limited judgment involved in such situations is not indicative of supervisory status.

Beverly Manor Convalescent Centers, 275 NLRB 943, 946 (1985).

Other Factors

Another argument advanced by the Employer is that team leaders are the highest ranking personnel present in their hospital units during certain periods of time. The record indicates, however, that nurse managers are responsible for their units 24 hours a day, 7 days a week, and can be paged at anytime. In addition, there is always a house or hospital manager present in the building to handle problems which team leaders may encounter. The Board has found employees not to be supervisors even though they are the highest ranking employee on duty. See, e.g., *St. Francis Medical Center-West*, 323 NLRB 1046, 1047 (1997). There is no evidence that team leaders' direction of employees during the times they are the highest ranking employee is anything other than routine. Under the circumstances here, I find that this factor does not support a finding of supervisory status.

The Employer points out that team leaders spend very little time directly involved in patient care. One team leader testified that she spends from 15 to 20% of her time providing direct patient care. I find that this evidence does not require a finding of supervisory status where the employee's non-patient-care activities are routine.

Supervisory Status of Chief Flight Nurse

At hearing, the Petitioner took the position that the chief flight nurse is a statutory supervisor who should not be included in the appropriate unit. No basis for its position was offered, and the Petitioner's post-hearing brief did not address the issue. The only record evidence regarding this position is the uncontroverted testimony of Kathleen Mayer, the chief flight nurse for the Flight For Life program. She testified that she spends 70 to 80% of her time working as a flight nurse, and that she has no authority to hire, discipline, suspend, or promote employees. Mayer participates in the evaluation process, but does not actually prepare the evaluation and does not sign it. In regard to discipline, Mayer tells the nurse manager if she thinks an employee needs to be written up. Her role in scheduling is to fill the holes in the schedule, a clerical task which is protocol driven and not involving independent judgment. She also testified that she has no authority with respect to overtime, breaks, or attendance.

Based upon the record evidence, I find that the chief flight nurse does not possess supervisory authority, and accordingly, should be included in the appropriate unit.

ELIGIBILITY OF PRNs AND PER DIEM RNs

The Parties also disagree over the placement of certain part-time RNs known as "per diems" and "PRNs." The Employer would include all of these RNs who are on the payroll, or alternatively, all such employees who average working eight hours per week during the preceding quarter. The Petitioner would include

all per diem RNs and PRNs who average working four hours per week during the preceding quarter. The Employer has approximately 57 per diem employees working at all facilities. They are casual, on-call staff employees who are required to work a minimum of one shift per month. There are also approximately 268 PRNs who work as needed at the different facilities. The PRNs sign a contract requiring them to work a minimum of four shifts per month, including some weekend and holiday shifts. There is no dispute that the per diems and PRNs perform typical RN nursing functions when they are scheduled to work.

I find that the per diems and PRNs are on-call employees who work on a regular basis, as needed. Therefore, the Board's eligibility formula for on-call employees, as set forth in *Davison-Paxon Co.*, 185 NLRB 21, 24 (1970),²⁰ applies here. Thus, all per diem RNs and PRNs who regularly average four hours or more of work per week during the quarter prior to the eligibility date will be eligible to vote.

5. The following employees of the Employer constitute a unit appropriate for the purpose of collective bargaining within the meaning of Section 9(b) of the Act:²¹

²⁰ See also *Sisters of Mercy Health Corp.*, 298 NLRB 483 (1990).

²¹ The parties stipulated that the certified RN anesthetists, family education coordinator, procedural RN, interventional cardiovascular specialists I and II, clinical nurse specialist, paramedic course facilitator, trauma nurse coordinator, and infection control nurse should all be included in the appropriate unit. Based upon the stipulation, which is in accord with the record evidence, I find that they should be included. The parties also stipulated that there is no RN currently in the utilization review coordinator or the crisis assessment coordinator positions. Therefore, it is not necessary to decide the placement of those positions. The Parties further stipulated that the position of administrative coordinator (also known as hospital manager or house manager) should be excluded from the unit, apparently because of supervisory authority. Based upon that stipulation, and the evidence supporting it, I find that the position should not be included.

INCLUDED: All full-time and regular part-time graduate and registered nurses (RNs) employed by the Employer at its acute care hospitals known as St. Anthony Central (SAC), located at 4231 West 16th Avenue, Denver, Colorado, and St. Anthony North (SAN), located at 2551 West 84th Avenue, Westminster, Colorado, including staff RNs, team leaders, case manager RNs, pastoral nurse coordinator RNs, psychiatric triage specialist RNs, education/project specialist RNs, Flight For Life Program RNs at SAC and SAN (including chief flight nurse), Intermountain Neurosurgery and Neuroscience Clinic RNs and nurse practitioners, clinical RNs I, clinical RNs II, infection control nurse, procedural RN, family education coordinator, interventional cardiovascular specialists I and II, clinical nurse specialist, paramedic course facilitator, trauma nurse coordinator, and certified RN anesthetists.

EXCLUDED: Supervisors and all other employees, including nurse managers, administrative coordinators, Senior Health Center RNs, Senior Health Clinic at Range Vista RNs, Transitional Care Unit RNs, Intensive Outpatient Program RNs, physician services representatives, clinical outcomes coordinators, regulatory compliance coordinator, and all RNs employed at the Granby Medical Clinic, Aurora Joint Venture (JV) After Hours Clinic, Southwest Plaza JV After Hours Clinic, Summit Medical Center, Gilpin County After Hours Clinic, Broomfield Family Practice, and Family Medicine North Clinic.

DIRECTION OF ELECTION

An election by secret ballot shall be conducted by the undersigned among the employees in the unit found appropriate at the time and place set forth in the notice of election to issue subsequently, subject to the Board's Rules and Regulations.²² Eligible to vote are those in the unit who are employed during the payroll period ending immediately preceding the date of the Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible are employees engaged in an

²² The Petitioner expressed a willingness to proceed to an election in any unit found appropriate.

economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period, and their replacements. Those in the military services of the United States Government may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 105

LIST OF VOTERS

In order to ensure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties in the election should have access to a list of voters and their addresses which may be used to communicate with them. ***Excelsior Underwear, Inc.***, 156 NLRB 1236 (1966); ***NLRB v. Wyman-Gordon Company***, 394 U.S. 759 (1969). Accordingly, it is hereby directed that within seven (7) days of the date of this Decision, two (2) copies of an election eligibility list containing the names and addresses of all the eligible voters shall be filed by the Employer with the undersigned, who shall make the list available to all parties to the election. In

order to be timely filed, such list must be received in the NLRB Region 27 Regional Office, 600 17th Street, Suite 700 North, Denver, CO 80202 , on or before August 11, 2000. No extension of time to file this list shall be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed.

RIGHT TO REQUEST REVIEW

Under the provision of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, N.W., Washington, DC 20570. This request must be received by the Board in Washington by August 18, 2000. In accordance with Section 102.67 of the Board's Rules and Regulations, as amended, all parties are specifically advised that the election will be conducted when scheduled, even if a request for review is filed, unless the Board expressly directs otherwise.

Dated at Denver, Colorado, this 4th day of August, 2000.

/s/ Daniel C. Ferguson _____
Daniel C. Ferguson
Acting Regional Director
Region 27
National Labor Relations Board
700 N, Dominion Plaza
600 Seventeenth Street
Denver, Colorado 80202-5433

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